# Medical History and Physical Assessment

CCS CORRECT CARE SOLUTIONS

| *Patient Name* | *Patient Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

| Problems | Yes | No | Problems | Yes | No |
|---|---|---|---|---|---|
| Anemia | | | Hypertension | | |
| Arthritis | | | Joint Problem | | |
| Asthma | | | Kidney Disease | | |
| Balance/Dizziness | | | Lice or Scabies | | |
| Blackouts | | | Liver | | |
| Bladder Infection | | | Muscle Problem | | |
| Blood | | | Nausea/Vomiting | | |
| Cough/Sputum | | | Nervous Disorder | | |
| D.T.'s | | | Oral Pain/Discomfort | | |
| Diabetes | | | Pneumonia | | |
| False Teeth | | | Recent Injury | | |
| Gall Bladder | | | Seizures | | |
| Gonorrhea | | | Stomach Pain | | |
| Hay Fever | | | Syphilis | | |
| Headache | | | Teeth | | |
| Hearing | | | Throat | | |
| Heart | | | Trouble Voiding | | |
| Heartburn | | | Tuberculosis | | |
| Hepatitis | | | Ulcer | | |
| Hernia | | | Other problems, diets or appliances: | | |

**Immunization Status**

Date of last tetanus:_____

Other (Influenza, Pertussis, Hepatitis, etc.):

**PPD Status:** ☐ Past Positive

Previous Treatment with Meds: ☐ Yes ☐ No

Was treatment completed? ☐ Yes ☐ No

Date of Positive PPD:_____

Where diagnosed:_____

☐ No history of past positive

☐ Unexplained weight loss

☐ Fever or Chills

☐ Night sweats

☐ Chronic cough – lasting 3 weeks or longer / Bloody sputum

**Vision** (Snellen Chart)

RT _____ w/ glasses _____

LT _____ w/ glasses _____

Both _____ w/ glasses _____

| | | | |
|---|---|---|---|
| Breast Exam | ☐ Normal | ☐ Abnormal | ☐ Deferred |
| Rectal Exam | ☐ Normal | ☐ Abnormal | ☐ Deferred |
| Testicular Exam | ☐ Normal | ☐ Abnormal | ☐ Deferred |

| | | |
|---|---|---|
| Receiving Screen Form Reviewed | ☐ Yes | ☐ No |
| Educational Materials Provided | ☐ Yes | ☐ No |
| Oral Hygiene Instructions Provided | ☐ Yes | ☐ No |

**ALLERGIES**

Age____ Sex____ Race____ Ht____ Wt____

Pulse_____ BP_____ Resp_____ Temp_____

| | | *Normal* | *Abnormal* |
|---|---|---|---|
| Skin | Color | | |
| | Condition | | |
| | Turgor | | |
| Eyes | Pupils | | |
| | Sclera | | |
| | Conjunctiva | | |
| Ears | Appearance | | |
| | Canals | | |
| | Hearing | | |
| Mouth | Throat | | |
| | Tongue | | |
| | Tonsils | | |
| | Teeth Condition | | |
| | Gums Condition | | |
| | False Teeth | | |
| Nose | Obstructions | | |
| | Drainage | | |
| Neck | Veins | | |
| | Mobility | | |
| | Thyroid | | |
| | Carotids | | |
| | Lymph Nodes | | |
| Chest | Configuration | | |
| | Auscultation | | |
| | Respirations | | |
| Heart | Auscultation | | |
| | Radial Pulses | | |
| | Apical Pulse | | |
| | Rhythm | | |
| Extremities | Pulse | | |
| | Edema | | |
| | Joints | | |
| Spine | | | |
| Abdomen | Shape | | |
| | Bowel Sounds | | |
| | Palpitation | | |

**COMMENTS**

Examiner's Signature / Title _____ Date _____ Physician's Signature _____ Date _____





*D170290DP30281P*

# Mental Health Screening and Evaluation

CCS CORRECT CARE SOLUTIONS

| *Patient Name* | *Patient Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

## Suicide Potential Screening

1. Have you ever attempted suicide? **YES** **NO**
   When:
   How:
2. Have you recently considered attempting suicide? **YES** **NO**
   If YES, explain
3. Note circumstances that increase suicide potential:

## Current Mental Status
(✓ All that apply)

**Orientation**
__Alert, Oriented __Disoriented

**Affect**
__Appropriate __Flat
__Inappropriate

**Mood**
__Appropriate __Depressed
__Terrified/crying __Elated
__Angry

**Speech**
__Appropriate __Slurred
__Pressured __Slowed
__Loud

**Appearance**
__Neat & Clean __Dirty
__Disheveled

**Hallucinations**
__Visual __Auditory
__Tactile __Olfactory

**Activity / Behavior**
__Appropriate __Unable to sit still
__Slow __No eye contact

**Thought Process**
__Logical __Paranoid
__Does not make sense

## Summary

__ No mental health problems

__ Mental health problems requiring routine follow-up

__ Chronic mental health problem
- __ Mental Illness
- __ Developmental disability
- __ Other_____

__ Acute mental health problem
- __ Psychosis
- __ Suicidal
- __ Other_____

__ Potential withdrawal from substance abuse

## Disposition

__ No mental health referral Approved for General Population

__ Routine mental health referral Approved for General Population

__ Mental Health Referral ASAP Special Housing

__ Mental Health Referral ASAP Suicide Precaution Procedure

__ Medical Monitoring for Potential Withdrawal

**Allergies:**

## Psychiatric Screening

1. History of or current psychotropic medication? **YES** **NO**
   List:
2. History of psychiatric hospitalization? **YES** **NO**
   When? Where?
3. History of outpatient mental health treatment? **YES** **NO**
4. History of substance abuse / treatment? (include therapy and/or medications ) **YES** **NO**
5. History of sex offenses? **YES** **NO**
6. History of victimization? **YES** **NO**
7. History of violent behavior? **YES** **NO**
8. History of cerebral trauma or seizures? **YES** **NO**
9. Family Situation (check)
   __Single __Married __Divorced
   __Separated __Widowed
   Family/Sig Other Supportive? **YES** **NO**
10. History of special education? **YES** **NO**
11. Education (highest grade completed):
12. Level of Cognitive Functioning (check)
    __Above Average __Below Average
    __Average
13. I/M concerned with ability to cope? **YES** **NO**

**COMMENTS** (Comment on all "YES" responses)

Screened by: _____ Date: _____ Time_____

Reviewed by: _____ Date: _____ Time: _____




*D17029DP3028 1P*

# Periodic Health Assessment

CCS CORRECT CARE SOLUTIONS

| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

| Age | Height | Weight | B/P | Pulse | Resp |
|---|---|---|---|---|---|
| | | | | | |

**TB Screening**

Previous Negative: ❑ Yes Planted: ❑ Yes ❑ Refused

Previous Positive: ❑ Yes *If YES, Complete Symptom Screen below:*

❑ Yes ❑ No Unexplained Weight Loss
❑ Yes ❑ No Fever or Chills
❑ Yes ❑ No Night Sweats
❑ Yes ❑ No Chronic Cough - lasting 3 weeks or longer
❑ Yes ❑ No Bloody or Productive Cough

**Pap Smear**

Date of Last Pap: _____ ❑ Performed ❑ Not Due

*Age 11-65: every 3 years from onset of sexual activity and in those with normal previous screenings.*
*Age 65 and Older: Only when not previously screened or with previous abnormal screenings.*

**Mammogram**

*Age 40-69: Every 1-2 years* ❑ Scheduled ❑ Not Due

**Fecal Occult Blood Test** *(Age 50 and Older)*

Results: ❑ Positive ❑ Negative ❑ Declined

**Physical** (when indicated):

❑ Yes ❑ No

**Vision Screening** *(Age 65 and Older)*

Snellen: OU_____ OD_____ OS_____

**Hearing Screening** *(Age 65 and Older)*

❑ Obvious Impairment ❑ None Noted

**Special Circumstance:**

Male >74 who has ever smoked: ❑ Ultrasound for AAA
Female >65: ❑ One time Bone Density test for Osteoperosis

**Have you had any health changes since your last exam?**

❑ Yes *(note below)* ❑ No

**Comments:** _____

Assessed by: Date:

Physician Review: Date:




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